Partners in Pediatrics & Family Health

303 W. MEMORIAL BLVD., W.
HAGERSTOWN, MARYLAND 21740
Phone: 301-791-7060 Fax: 301-791-8990

Authorization for Release of Patient Identifiable Health Information

Date of Request: _____

I, _____ hereby authorize Partners in Pediatrics and Family Health.

_____ To Release To _____ To Obtain From

_____
Name of Physician, Hospital, Insurance Company, Self, Etc.

_____
Address, City, State, Zip code

The following information will be released from the Medical Records of:

_____ _____ _____
Patient Name D.O.B Social Security Number

Specific Information to be disclosed: ____ Entire Medical Record ____ Immunization Record
____ Other (please specify) _____

This Health Information is need for:

___ Personal Use ___ Continuing Medical Care ___ School
___ Leaving Practice ___ Legal Reasons ___ Military
___ Social Security Disability ___ Other

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, or communicable disease. I authorize the disclosure of the specific information.

Sign : _____

- I also understand that the person giving authorization by written and dated notice to the Medical Record Department may revoke this authorization. Iniial _____
- I understand that this revocation will not apply to information that has already been released in response to this authorization.
- I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Initial: _____
- This authorization expires one year from the date of signature, unless I specify otherwise or revoke it, Initial : _____
- I understand I may be charged for copies of my healthcare information. Initial :_____
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information. Iinitial : _____
- I understand authorizing the use or disclosure of the health information identified above is voluntary. I need not sign this to ensure healthcare treatment. Initial :_____

_____ _____ _____ _____
Signature of Patient Date Signature of Parent (If Minor Patient) Date

There is a $25 charge for copy of each complete medical record for those transferring from this office.
Note that this document is valid for only one year.